DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Disability and Elder Services
DDE-287 (Rev. 2-05)

COMMUNITY BASED RESIDENTIAL FACILITY (CBRF)
INITIAL LICENSE APPLICATION

Completion of this form is required by s. 50.03(3)(b), Wis. Stats. Failure to complete this form, completely and accurately, may result in licensure denial and/or delay in processing. Send the completed form, with the items listed below, to the Bureau of Quality Assurance (BQA) regional office assigned to the county in which the facility is located. BQA regional office locations are found at http://dhfs.wisconsin.gov/bqaconsumer/AssistedLiving/ALSreglmap.htm. Contact the appropriate regional office if you have questions about completion of this form.

THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THE APPLICATION FORM:

- Program Statement
- Fire Inspection
- License Fee – Check payable to DDES **(NON-REFUNDABLE)**
- Floor plan with dimensions, exits and room usage

The licensee is responsible for notifying the Bureau of Quality Assurance, in writing, of any change in the information provided on this application.

CHECK SIZE OF CBRF	CHECK CLASS / TYPE OF CBRF	
☐ Small (5-8 residents) ☐ Medium (9-20 residents) ☐ Large (21 or more residents)	☐ Ambulatory Class A (AA) ☐ Semi-Ambulatory Class A (AS) ☐ Non-Ambulatory Class A (ANA)	☐ Ambulatory Class C (CA) ☐ Semi-ambulatory Class C (CS) ☐ Non-ambulatory Class C (CNA)

NOTE: Any change in the above information requires submission of new documents.

GENERAL INFORMATION

Name – Facility		Facility Telephone No.
Facility Street Address / PO Box		FAX Number
City, State, Zip Code	County	Fire Number
Name – Administrator		Birthdate – Administrator

Provide specific directions to the facility from the closest major STATE highway.

Name – Licensee	Birthdate
Street Address – Licensee	Telephone Number
City, State, Zip Code	

Does the Community Based Residential Care Facility have a contract with a county human services or social services department to serve Medicaid waiver eligible individuals?

☐ Yes ☐ No

Provide the name and address of the person to whom mail and correspondence from the Department is to be addressed.

Name

Mailing Address

City, State, Zip Code

List the names of all persons, age 10 and older, who live in the facility and are not a resident.
If more than four names attach an additional sheet.

Last Name, First Name and MI	Relationship to Licensee	Birthdate

FACILITY INFORMATION

Total Resident Capacity	☐ Female ☐ Male ☐ Both

Check the box indicating the primary client group(s) served by your CBRF. If more than one client group is served, see HFS 83.07(2) for instructions.

- ☐ AA Advanced aged (60+ years)
- ☐ ALZ Irreversible dementia/Alzheimer's
- ☐ DD Developmentally Disabled (DD)
- ☐ MH Emotionally disturbed/Mental illness
- ☐ ADA Alcohol/Drug dependent
- ☐ PD Physically disabled
- ☐ PWC Pregnant women who need counseling
- ☐ CC Correctional clients
- ☐ TI Terminally ill
- ☐ TBI Traumatic brain injury
- ☐ ADS Persons with acquired immunodeficiency syndrome (AIDS)

List days and hours when residents are **NOT** in the facility.

Days	Hours

Indicate the minimum and maximum monthly fees charged for resident care. Include fees paid from all sources including government and/or private agencies, the resident's family or relatives and from the resident. If you charge the same fee to all of your residents, indicate the amount as the "Maximum" rate.

Minimum MONTHLY Rate	Maximum MONTHLY Rate

Provide the facility's monthly Operating Expenses

	All Salaries, i.e., licensee, caregivers, contract providers, etc.		
	Lease or Mortgage		
	All Other, i.e., food, supplies, utilities, insurance, taxes, etc.		
	Total Monthly Expenses		

If income from residents would not be adequate to pay your monthly operating expenses, you must have other sources of funds or income that may be used to continue the operation of the facility for at least a 60-day period.

Check all other sources of income:

- ☐ Savings or Other Financial Reserves
- ☐ Purchase Contract (County Department)
- ☐ Outside Employment
- ☐ Income From Another Business
- ☐ Contract or Agreement with Private or Non-Profit Agency
- ☐ Line of Credit
- ☐ Loan
- ☐ Other (specify)

Have you ever applied for licensure for a residential facility, health care facility or a day care program for adults or children and been denied licensure?

☐ Yes ☐ No

If Yes, explain and provide relevant information.

Have you ever operated a residential facility, health care facility or a day care program for adults or children in Wisconsin or in any other state?

☐ Yes ☐ No

If yes, provide the name, address and phone number of the facility/program.

Was the facility/program licensed, certified or otherwise regulated by any government or private agency?

☐ Yes ☐ No

If yes, provide the name, address and phone number of that agency.

Have you ever had any license, certification or governmental approval to operate a facility/program denied, revoked, suspended or not renewed?

☐ Yes ☐ No

If yes, specify the type of license, certification or approval affected, in which state the action occurred, which agency took the enforcement action, and the name, address, phone number and type of facility/program that was affected.

Do you presently have or intend to apply for another type of license, certification, or registration at this location?

☐ No ☐ Yes (Check below all that apply.)

LICENSE TYPE

- ☐ a. Adult Family Home
- ☐ b. Facility for Developmentally Disabled
- ☐ c. Foster Home (Children)
- ☐ d. Group Home (Children)
- ☐ e. Residential Care Center for Children and Youth
- ☐ f. Child Day Care
- ☐ g. Shelter Care (Children)

CERTIFICATION TYPE

- ☐ a. Adult Day Care
- ☐ b. Residential Care Apartment Complex
- ☐ c. Alcohol and Other Drug Abuse Program
- ☐ d. Developmental Disabilities Program
- ☐ e. Mental Health Program
- ☐ f. Other

REGISTRATION TYPE

- ☐ a. Residential Care Apartment Complex
- ☐ b. Other

Local fire departments have requested knowing where licensed facilities are located. Provide the name, address and telephone number of your local fire department.

Name - Local Fire Department	Telephone No. (Do NOT enter 911)
Address (Street / PO Box, City, State and Zip Code)	

A request will be sent to the City, Township or Village to identify any possible hazard that may affect the health and safety of the residents. No license may be granted until a 30-day period has expired or until we receive a response from the City, Township or Village.

☐ City ☐ Township ☐ Village

Municipality Name

Address (Street / PO Box, City, State and Zip Code)

Name – Clerk

OWNERSHIP

List all names, principal business addresses and the percentage and type of ownership interest of all persons or business entities having any ownership interest whatsoever in the facility, whether direct or indirect, and whether the interest is in the profits, land, or building, including owners of any business that owns any part of the land or building. If a partnership, then list each partner. If a corporation, then list each officer and director of the corporation. If any person or business entity named is a bank, credit union, savings and loan association, investment association or insurance corporation, it is sufficient to name the entity involved without providing information regarding the officers and directors of the entity.

NOTE: Attach additional pages if needed for the following questions.

LICENSEE / OPERATOR

1. THE LICENSEE (OPERATOR) OWNS THE:

Operation	Building	Land
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2. TYPE OF LICENSEE (OPERATOR). Check one of the following:

Governmental	Proprietary	Voluntary Non-Profit
☐ City ☐ County ☐ State	☐ Individual ☐ Married Couple ☐ Partnership ☐ Corporation ☐ Limited Liability Co.	☐ Corporation ☐ Church ☐ Association ☐ Church/Corporation ☐ Limited Liability Co.

3. List the interested parties relative to the entity named as LICENSEE. (s.50.03(3), Wis. Stats.)

Name (Last, First, MI) – Title	Percent of Financial Interest
Address (Street / PO Box, City, State Zip Code)	
Name (Last, First, MI) – Title	Percent of Financial Interest
Address (Street / PO Box, City, State Zip Code)	
Name (Last, First, MI) – Title	Percent of Financial Interest
Address (Street / PO Box, City, State Zip Code)	
Name (Last, First, MI) – Title	Percent of Financial Interest
Address (Street / PO Box, City, State Zip Code)	

4. Has the Licensee ever been adjudicated bankrupt? ☐ Yes ☐ No

   If YES, give full details on a separate page including dates, court, and the disposition of each matter.

5. Are there any unsatisfied judgments against the Licensee? ☐ Yes ☐ No

   If YES, list all judgments on a separate page listing names and addresses of creditors, amounts and reasons for non-payment.

6. Does the Licensee owe any debts that are 90 days past due? ☐ Yes ☐ No

   If YES, list all debts 90 days past due on a separate page listing the names and addresses of creditors, amounts and reasons for non-payment.

7. Are any liens filed against the Licensee or the Licensee's property? ☐ Yes ☐ No

   If YES, indicate on a separate page who filed the lien(s), where filed, when filed, and the amount of each lien.

If someone other than the Licensee (Operator) has ownership interest in the building and / or land, complete the set of questions numbered 8-11 and, if applicable, the set of questions numbered 12-15, allowing one set of questions for each different partnership, corporation and other type of owner.

8 OWNER OF THE: ☐ Building ☐ Land

9. TYPE OF OWNER (Check one of the following.)

Governmental	Proprietary	Voluntary Non-Profit
☐ City ☐ County ☐ State	☐ Individual ☐ Married Couple ☐ Partnership ☐ Corporation ☐ Limited Liability Co.	☐ Corporation ☐ Church ☐ Association ☐ Church/Corporation ☐ Limited Liability Co.

10. NAME AND ADDRESS OF THE OWNER

Name – Individual, Partnership, Corporation, etc.

Address (Street / PO Box, City, State and Zip Code)

11. LIST THE INTERESTED PARTIES RELATIVE TO THE ENTITY IN QUESTION 10. (s.50.03(3), Wis. Stats.)

Name (First. Last, MI)	Percent of Financial Interest
Address (Street / PO Box, City, State and Zip Code)	
Name (First, Last, MI)	Percent of Financial Interest
Address (Street / PO Box, City, State and Zip Code)	

12. OWNER OF THE ☐ Land

13. TYPE OF OWNER (Check one of the following.)

Governmental	Proprietary	Voluntary Non-Profit
☐ City ☐ County ☐ State	☐ Individual ☐ Married Couple ☐ Partnership ☐ Corporation ☐ Limited Liability Co.	☐ Corporation ☐ Church ☐ Association ☐ Church/Corporation ☐ Limited Liability Co.

14. NAME AND ADDRESS OF THE OWNER

Name (Individual, Partnership, Corporation, etc.)

Address (Street Address / PO Box, City, State and Zip Code)

15. LIST THE INTERESTED PARTIES RELATIVE TO THE ENTITY IN QUESTION 14. (s.50.03(3), Wis. Stats.)

Name (First, Last, MI) – Title	Percent of Financial Interest
Name (First, Last, MI)m – Title	Percent of Financial Interest

CREDITORS

1. List the names, principal business addresses, telephone numbers and type and extent of obligation, in dollars, for all creditors holding a security interest in the premises, whether land or building. Include any mortgage, note, deed of trust, or other obligation secured in whole or in part by the land on which, or building in which, the facility is located. Attach additional pages if necessary.

Name (Individual, Partnership, Corporation, etc.)		
Address (Street / PO Box, City, State and Zip Code)		
Telephone No.	Type	Extent
Name (Individual, Partnership, Corporation, etc.)		
Address (Street / PO Box, City, State and Zip Code)		
Telephone No.	Type	Extent
Name (Individual, Partnership, Corporation, etc.)		
Address (Street / PO Box, City, State and Zip Code)		
Telephone	Type	Extent

2. List the names, principal business addresses, telephone numbers, and type and extent of agreement, in dollars, for all persons and business entities holding any lease or sublease for the land where the building is located. Attach additional pages if necessary.

Name (Individual, Partnership, Corporation, etc.)		
Address (Street / PO Box, City, State and Zip Code)		
Telephone No.	Type	Extent
Name (Individual, Partnership, Corporation, etc.)		
Address (Street / PO Box, City, State and Zip Code)		
Telephone No.	Type	Extent

State of Wisconsin)
)
County of _____)

NOTE: This application must be notarized.

The licensee is responsible for notifying the Bureau of Quality Assurance, in writing, of any changes in the information provided on this application.

I swear or affirm that all statements made in this application and any attachments are correct to the best of my knowledge and that I will comply with all laws, rules and regulations governing the licensing of Community Based Residential Facilities in Wisconsin.

_____
PRINT OR TYPE NAME

_____ _____
Date Signed Signature (In Full) - Licensee or Designee

_____
(Corp. Seal) Title (Must be Owner or Board Member)

Subscribed and sworn to before me this _____ day

of _____, _____

_____, Notary Public (Notary Seal)

_____ County, Wisconsin

My Commission Expires_____